STATE OF MARYLAND
DEPARTMENT OF HEALTH & MENTAL HYGIENE
MEDICAL ASSISTANCE PROGRAM

PERSONAL CARE PROGRAM
300 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201

INTAKE FOR PERSONAL CARE SERVICES

1. NAME OF APPLICANT: _____

   ADDRESS: _____ COUNTY: Frederick

   CITY: _____ STATE: MD ZIP CODE: _____

   PHONE: _____ DATE OF BIRTH: _____

2. PERSONAL PHYSICIAN: _____

   ADDRESS: _____

   MD

   PHONE: _____

3. MEDICAID ELIGIBILITY: ☐ YES ☐ NO ☐ UNCERTAIN

   IF YES, EFFECTIVE DATES: _____
   Beginning End Medical Assistance #

4. CURRENT CONDITION OF APPLICANT: ☐ Chronically Ill ☐ Disabled ☐ Elderly

5. WHY IS SERVICE REQUESTED:

6. MAJOR DIAGNOSIS:

7. NAME OF POSSIBLE PROVIDER: _____

   ADDRESS: _____

   MD

   RELATIONSHIP: _____ PHONE: _____

8. NAME OF PERSON CALLING: _____

   ADDRESS: _____

   MD

   RELATIONSHIP: _____ PHONE: _____

9. REFERRED BY: _____ PHONE: _____

   AGENCY: _____

INFORMATION RECEIVED BY: _____ DATE: _____

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